

		FOR OHF USE					

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**2004**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2004)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0040733</u></p> <p><b>Facility Name:</b> <u>Alden Estates of Evanston</u></p> <p><b>Address:</b> <u>2520 Gross Point Road</u> <u>Evanston</u> <u>60201</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 286-3883</u> <b>Fax #</b> <u>(773) 286-3743</u></p> <p><b>IDPA ID Number:</b> <u>36-4003478</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/15/96</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steven M. Kroll</u> <b>Telephone Number:</b> <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2004</u> to <u>12/31/2004</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Steven M. Kroll</u></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p style="text-align: center;"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Steven M. Kroll</u>		(Title) <u>Chief Financial Officer</u>	<b>Paid Preparer</b>	(Signed) _____ (Date) _____		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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	(Telephone) <u>( )</u> Fax # ( )																																						

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Estates of Evanston# 0040733 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>42</u>	Skilled (SNF)	<u>42</u>	<u>15,372</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>57</u>	Sheltered Care (SC)	<u>57</u>	<u>20,862</u>	5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>400</u>	<u>1,453</u>	<u>9,608</u>	<u>11,461</u>	8
9	SNF/PED					9
10	ICF	<u>1,110</u>	<u>411</u>		<u>1,521</u>	10
11	ICF/DD					11
12	SC		<u>11,035</u>		<u>11,035</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>1,510</u>	<u>12,899</u>	<u>9,608</u>	<u>24,017</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 66.28%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Day care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 3/15/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 3/15/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 42 and days of care provided 9,608Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	387,850	22,333		410,183	284	410,467		410,467		1
2	Food Purchase		158,388		158,388	(22,808)	135,580	(1,006)	134,574		2
3	Housekeeping	64,275	23,901		88,176	195	88,371		88,371		3
4	Laundry	45,952	12,626		58,578	79	58,657		58,657		4
5	Heat and Other Utilities			173,107	173,107		173,107	(4,545)	168,562		5
6	Maintenance	25,812	1,006	126,515	153,333	89	153,422	994	154,416		6
7	Other (specify):* related party salary							9,138	9,138		7
8	<b>TOTAL General Services</b>	523,889	218,254	299,622	1,041,765	(22,161)	1,019,604	4,581	1,024,185		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			67,450	67,450		67,450		67,450		9
10	Nursing and Medical Records	1,172,044	77,975	48,206	1,298,225	185	1,298,410	(74,246)	1,224,164		10
10a	Therapy	29,475			29,475		29,475		29,475		10a
11	Activities	49,894	2,078	6,468	58,440		58,440		58,440		11
12	Social Services	35,057			35,057		35,057		35,057		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* related party salary							6,833	6,833		15
16	<b>TOTAL Health Care and Programs</b>	1,286,470	80,053	122,124	1,488,647	185	1,488,832	(67,413)	1,421,419		16
	<b>C. General Administration</b>										
17	Administrative	73,110			73,110		73,110		73,110		17
18	Directors Fees										18
19	Professional Services			536,728	536,728		536,728	(410,603)	126,125		19
20	Dues, Fees, Subscriptions & Promotions			46,029	46,029		46,029	(37,311)	8,718		20
21	Clerical & General Office Expenses	150,341	19,535	104,622	274,498		274,498	(8,429)	266,069		21
22	Employee Benefits & Payroll Taxes			271,951	271,951	21,976	293,927	(256)	293,671		22
23	Inservice Training & Education										23
24	Travel and Seminar			(522)	(522)		(522)	2,951	2,429		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			88,174	88,174		88,174	9,313	97,487		26
27	Other (specify):* related party salary			40,816	40,816		40,816	59,831	100,647		27
28	<b>TOTAL General Administration</b>	223,451	19,535	1,087,798	1,330,784	21,976	1,352,760	(384,504)	968,256		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,033,810	317,842	1,509,544	3,861,196		3,861,196	(447,336)	3,413,860		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Alden Estates of Evanston

#0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			32,507	32,507		32,507	182,451	214,958			30
31	Amortization of Pre-Op. & Org.							7,823	7,823			31
32	Interest			303,976	303,976		303,976	347,304	651,280			32
33	Real Estate Taxes							211,205	211,205			33
34	Rent-Facility & Grounds			1,057,183	1,057,183		1,057,183	(1,057,183)				34
35	Rent-Equipment & Vehicles			5,516	5,516		5,516	4,953	10,469			35
36	Other (specify):*							39,155	39,155			36
37	<b>TOTAL Ownership</b>			1,399,182	1,399,182		1,399,182	(264,292)	1,134,890			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		502,653	677,728	1,180,381		1,180,381	(131,876)	1,048,505			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		48		48		48	(48)				41
42	Provider Participation Fee			23,058	23,058		23,058		23,058			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		502,701	700,786	1,203,487		1,203,487	(131,924)	1,071,563			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,033,810	820,543	3,609,512	6,463,865		6,463,865	(843,552)	5,620,313			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

## STATE OF ILLINOIS

Page 5

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,491)	30		9
10	Interest and Other Investment Income	(104)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,418)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,226)	21		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(60)	32		18
19	Entertainment	(3,969)	20		19
20	Contributions	(931)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,835)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(40,815)	27		24
25	Fund Raising, Advertising and Promotional	(31,303)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,152)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(378,312)	Various	34
35	Other- Attach Schedule	(344,088)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (722,400)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (843,552)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Estates of Evanston

ID# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Valet Costs	\$ (43,914)	21	1
2	Late fees on utilities	(5,222)	5	2
3	Gift shop expenses	(48)	41	3
4	Other nursing income	240	21	4
5	Intercompany Interest	(292,826)	32	5
6	Misc Income telephon use	(2,842)	21	6
7	Marketing Manager	(1,923)	21	7
8	Back out 31.78% of IHCA dues	(1,227)	20	8
9	Marketing Manager employee benefits	(256)	22	9
10	Depereciaton adjustment	3,858	30	10
11	Deferredmaintenance adjustment	72	6	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(344,088)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,418)	0	0	1,412	0	0	0	0	0	0	0	(1,006)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,222)	0	677	0	0	0	0	0	0	0	0	(4,545)	5
6	Maintenance	72	0	2,023	0	0	0	(35)	(1,066)	0	0	0	994	6
7	Other (specify):*	0	0	9,138	0	0	0	0	0	0	0	0	9,138	7
8	<b>TOTAL General Services</b>	<b>(7,568)</b>	<b>0</b>	<b>11,838</b>	<b>1,412</b>	<b>0</b>	<b>0</b>	<b>(35)</b>	<b>(1,066)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,581</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(26,352)	(47,894)	0	0	0	0	0	0	(74,246)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	6,833	0	0	0	0	0	0	0	0	6,833	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>6,833</b>	<b>(26,352)</b>	<b>(47,894)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(67,413)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,835)	4,372	(397,140)	0	0	0	0	0	0	0	0	(410,603)	19
20	Fees, Subscriptions & Promotions	(37,430)	0	119	0	0	0	0	0	0	0	0	(37,311)	20
21	Clerical & General Office Expenses	(50,665)	0	7,667	24,003	10,566	0	0	0	0	0	0	(8,429)	21
22	Employee Benefits & Payroll Taxes	(256)	0	0	0	0	0	0	0	0	0	0	(256)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,951	0	0	0	0	0	0	0	0	2,951	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	9,248	65	0	0	0	0	0	0	0	0	9,313	26
27	Other (specify):*	(40,815)	0	78,640	5,630	16,376	0	0	0	0	0	0	59,831	27
28	<b>TOTAL General Administration</b>	<b>(147,001)</b>	<b>13,620</b>	<b>(307,698)</b>	<b>29,633</b>	<b>26,942</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(384,504)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(154,569)</b>	<b>13,620</b>	<b>(289,027)</b>	<b>4,693</b>	<b>(20,952)</b>	<b>0</b>	<b>(35)</b>	<b>(1,066)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(447,336)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(17,633)	189,542	9,144	0	1,398	0	0	0	0	0	0	182,451 30
31	Amortization of Pre-Op. & Org.	0	7,432	391	0	0	0	0	0	0	0	0	7,823 31
32	Interest	(292,990)	626,024	11,098	0	758	2,414	0	0	0	0	0	347,304 32
33	Real Estate Taxes	0	208,863	1,622	0	720	0	0	0	0	0	0	211,205 33
34	Rent-Facility & Grounds	0	(1,057,183)	0	0	0	0	0	0	0	0	0	(1,057,183) 34
35	Rent-Equipment & Vehicles	0	0	4,953	0	0	0	0	0	0	0	0	4,953 35
36	Other (specify):*	0	39,155	0	0	0	0	0	0	0	0	0	39,155 36
37	<b>TOTAL Ownership</b>	<b>(310,623)</b>	<b>13,833</b>	<b>27,208</b>	<b>0</b>	<b>2,876</b>	<b>2,414</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(264,292) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(38,009)	(55,272)	(38,595)	0	0	0	0	0	(131,876) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(48)	0	0	0	0	0	0	0	0	0	0	(48) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>(48)</b>	<b>0</b>	<b>0</b>	<b>(38,009)</b>	<b>(55,272)</b>	<b>(38,595)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(131,924) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(465,240)</b>	<b>27,453</b>	<b>(261,819)</b>	<b>(33,316)</b>	<b>(73,348)</b>	<b>(36,181)</b>	<b>(35)</b>	<b>(1,066)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(843,552) 45</b>



Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6K		See page 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent Income	\$ 1,057,183	Alden Estates of Evanston II, Inc.		\$	\$ (1,057,183)
2	V	32 Investments -RR	320	Alden Estates of Evanston II, Inc.			(320)
3	V	19 Audit		Alden Estates of Evanston II, Inc.		3,950	3,950
4	V	19 Professional fees		Alden Estates of Evanston II, Inc.			
5	V	19 Misc. expenses		Alden Estates of Evanston II, Inc.		422	422
6	V	33 Real estate taxes		Alden Estates of Evanston II, Inc.		208,863	208,863
7	V	26 Property & liability insurance		Alden Estates of Evanston II, Inc.		9,248	9,248
8	V	32 Interest on mortgage payable		Alden Estates of Evanston II, Inc.		626,344	626,344
9	V	36 Mortgage insurance premium		Alden Estates of Evanston II, Inc.		39,155	39,155
10	V	30 Depreciation		Alden Estates of Evanston II, Inc.		189,542	189,542
11	V	31 Amortization		Alden Estates of Evanston II, Inc.		7,432	7,432
12	V						
13	V						
14	Total		\$ 1,057,503			\$ 1,084,956	\$ * 27,453

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional fees	\$ 399,537	Alden Management Services	0.00%	\$ 2,397	\$ (397,140)	15
16	V	21 Clerical and G & A		Alden Management Services		7,667	7,667	16
17	V	5 Utilities		Alden Management Services		677	677	17
18	V	6 Maintenance		Alden Management Services		2,023	2,023	18
19	V	24 Travel & seminar		Alden Management Services		2,951	2,951	19
20	V	26 Insurance		Alden Management Services		65	65	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services		119	119	21
22	V	30 Depreciation		Alden Management Services		9,144	9,144	22
23	V	31 Amortization		Alden Management Services		391	391	23
24	V	33 Real estate taxes		Alden Management Services		1,622	1,622	24
25	V	35 Rent-equipment/vehicles		Alden Management Services		4,953	4,953	25
26	V	32 Interest		Alden Management Services		11,098	11,098	26
27	V	7 Salaries-general serv		Alden Management Services		9,138	9,138	27
28	V	15 Salaries-health care		Alden Management Services		6,833	6,833	28
29	V	27 Salaries-general admin		Alden Management Services		78,640	78,640	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 399,537			\$ 137,718	\$ * (261,819)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	2 tube-feeding	\$	Prism Health Care	100.00%	\$ 1,412	\$ 1,412 15
16	V	10 nursing suplies	27,195	Prism Health Care		843	(26,352) 16
17	V	39 per diems/other supplies	86,384	Prism Health Care		48,375	(38,009) 17
18	V	21 gen'l & admin.		Prism Health Care		24,003	24,003 18
19	V	27 Gen'l and admin.		Prism Health Care		5,630	5,630 19
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 113,579			\$ 80,263	\$ * (33,316) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 drugs	\$ 247,607	Forum Extended Care II	100.00%	\$ 213,570	\$ (34,037)	15
16	V	10 house stock	1,373	Forum Extended Care II		1,185	(188)	16
17	V	39 I.V	154,478	Forum Extended Care II		133,243	(21,235)	17
18	V			Forum Extended Care II				18
19	V	21 gen'l & admin		Forum Extended Care II		10,566	10,566	19
20	V	32 interest		Forum Extended Care II		758	758	20
21	V	33 real estate tax		Forum Extended Care II		720	720	21
22	V	30 depreciation		Forum Extended Care II		1,398	1,398	22
23	V	27 Gen'l & Admin salary		Forum Extended Care II		16,376	16,376	23
24	V	10 pharmacy consulting	47,706	Forum Extended Care II			(47,706)	24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 451,164			\$ 377,816	\$ * (73,348)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 therapy	\$ 654,572	Community Physical Therapy	100.00%	\$ 615,977	\$ (38,595)	15
16	V	32 interest		Community Physical Therapy		2,414	2,414	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 654,572			\$ 618,391	\$ * (36,181)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 repairs and maintenance	\$ 24,240	Alden Bennett Construction	0.00%	\$ 24,205	\$ (35)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 24,240			\$ 24,205	\$ * (35)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Carpet Cleaning	\$ 7,865	Alden Realty-Carpet Care	0.00%	\$ 7,038	\$ (827)	15
16	V	6 Floor Cleaning	2,450	Alden Realty-Floor Care		2,211	(239)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 10,315			\$ 9,249	\$ * (1,066)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 6K

Facility Name &amp; ID Number ALDEN NURSING CENTER - EVANSTON

# 004-0733

Report Period Beginning: 01/01/04

Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Heather	Harvey
ANC Long Grove	Long Grove
ANC Waterford	Aurora
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Clinton, WI
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park of Barrington	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living



## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Estates of Evanston # 0040733 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	100.00	225,297	0.432	1.08	salary	\$ 2,467	27-7	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin		72,752	0.432	1.08	salary	797	15-7	2
3	Terry Magnusson c.	Maint. Supervisor	constuct/maint		49,458	0.432	1.08	salary	542	7-7	3
4											4
5											5
6											6
7	a. Floyd Schlosssberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg.										9
10											10
11											11
12											12
13								TOTAL	\$ 3,806		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Estates of Evanston # 0040733 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago  
 Phone Number ( 773 ) 286-3883  
 Fax Number ( 773 ) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">see page 8A (also on page 6A)</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge		X	Operations	\$57,000.00	4/00	\$ 8,000,800	\$ 7,771,521	05/2035	8.0300	\$ 626,344	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Related Party - AMS & T Syst	X		Working Capital							22,188	6	
7	Related Party - FECII	X		Working Capital							758	7	
8	Realted Party - CPT	X		Working Capital							2,414	8	
9	TOTAL Facility Related				\$57,000.00		\$ 8,000,800	\$ 7,771,521			\$ 651,704	9	
	B. Non-Facility Related*												
10	Interest Income on Corp	X										10	
11	Interest Income on Even II	X									(320)	11	
12	Resident Interest		X								(104)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (424)	14	
15	TOTALS (line 9+line14)						\$ 8,000,800	\$ 7,771,521			\$ 651,280	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,155 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	202,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	202,663	2
3. Under or (over) accrual (line 2 minus line 1).				\$	163	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	208,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	208,863	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999	215,336	8		
		2000	220,724	9		
		2001	193,457	10		
		2002	196,564	11		
		2003	202,663	12		
2004 accrual based on 103% of 2003 paid taxes				13	FROM R. E. TAX STATEMENT FOR 2003 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Estates of Evanston COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040733

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>10-10-200-077-000</u>	<u>Nursing Home Facility</u>	\$ <u>202,663.00</u>	\$ <u>202,663.00</u>
2. _____	<u>Related Party-Alden Management</u>	\$ <u>149,765.00</u>	\$ <u>1,622.00</u>
3. _____	<u>Relate Party Forum</u>	\$ <u>13,827.00</u>	\$ <u>720.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>366,255.00</u></u>	\$ <u><u>205,005.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet:
53,567

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
☒ YES
☐ NO

If so, please complete the following:

1. Total Amount Incurred:
260,098

2. Number of Years Over Which it is Being Amortized:
35

3. Current Period Amortization:
7,431

4. Dates Incurred:
3/31/95

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF/Assisted living	53,277	1995	\$ 350,000	1
2					2
3	TOTALS	53,277		\$ 350,000	3

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5	99		1995	1994	5,377,512	159,376	39	137,885	(21,491)	1,349,435	5
6	Building		1999		54,450	1,601	34	1,601		8,006	6
7											7
8	related party forum			1978	16,213		22			16,213	8
	Improvement Type**										
9	Repair: boiler, valve, elect. Fixtures, heater, TV antenna			1995	17,311	1,330	10-20	1,330		12,382	9
10	Install lawn sprinkler system			1996	19,670	1,311	15	1,311		10,965	10
11	Demolition, excavating, electricalwork, masonry			1996	39,481	2,715	25	2,715		20,107	11
12	Sign			1996	745	62	12	62		507	12
13	Sink			1996	1,366	68	20	68		586	13
14	Motor repair			1996	3,300	165	20	165		1,485	14
15	Elevator remodeling			1996	3,018	151	20	151		1,245	15
16	Install new electrical outlets			1997	2,542		5			2,542	16
17	Telephone system upgrade			1997	2,698	270	10	270		1,911	17
18	Repair panel			1998	3,631		5			3,631	18
19	Repair rainshields, relief valve			1998	7,117	712	10	712		4,685	19
20	Replace fan motor			1998	5,797		5			5,797	20
21	Electrical panel			1998	1,926	193	10	193		1,220	21
22	Replace freezer compressor			1998	3,457	346	10	346		2,189	22
23	Replace fire alarm sys			1998	56,459	3,764	15	3,764		23,524	23
24	Elm heating-cooler-hvac			1999	2,500	250	10	250		1,375	24
25	Aqua plumbing-water heater			1999	10,445	696	15	696		3,598	25
26	CSI-repair air maint. Handler unit			1999	1,855	185	10	185		1,082	26
27	New horizons-hook up phones			1999	1,827	183	10	183		1,020	27
28	Alden Bennett Const.			2000	7,160	716	10	716		3,580	28
29	The floor source-lobby & elevator carpeting			2000	3,652	730	5	730		3,530	29
30	Alden Bennett Const.-wallcovering			2000	1,350	270	5	270		1,305	30
31	DBS Contracting-repair lawn sprinkler			2000	2,281	228	10	228		1,026	31
32	CSI-install disposal			2000	2,341	468	5	468		2,068	32
33	Forx valley fire & safety-repair sprinkler system			2000	1,765	118	15	118		520	33
34	CSI-replace compressor			2000	1,770	177	10	177		782	34
35	Alden Bennett-seea/stripe parking lot, replace sidewalk			2000	5,582	625	5-15	625		2,720	35
36	Service on Elliot Will -CSI Coker			2001	5,205	521	10	521		1,562	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Capps plumbing repair for meter bypass line	2001	\$ 1,840	\$ 368	5	\$ 368	\$	\$ 1,104	37	
38	The floor source - lobby & elevator carpet	2001	944	189	5	189		566	38	
39									39	
40	ABC (amtech lighting)	2002	2,202	110	20	110		239	40	
41	New Horizon (replace main frame)	2002	1,745	349	5	349		901	41	
42	ABC - parquet ffloor	2003	5,398	540	10	540		1,035	42	
43	ABC - interior work - various - walls/bathroom	2003	8,703	870	10	870		1,596	43	
44	ABC - replaced HID Ballasts (3) HID Lamp (1)	2003	2,870	287	10	287		526	44	
45	Csi-Coker - door gasket/safety switch	2003	2,480	496	5	496		785	45	
46	ABC - sewage ejector pump - install	2003	6,104	610	10	610		814	46	
47	ABC	2003	6,955	695	10	695		753	47	
48	US Foods - steamer	2003	1,059	212	5	212		229	48	
49	ABC-fence work	2004	1,875	234	8	234		234	49	
50	ABC-interior work various walls/bathroom	2004	2,540	169	10	169		169	50	
51	ABC-replaced HID ballasts	2004	1,406	29	20	29		29	51	
52									52	
53									53	
54									54	
55									55	
56									56	
57									57	
58									58	
59									59	
60									60	
61									61	
62									62	
63									63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 5,710,547	\$ 182,389		\$ 160,898	\$ (21,491)	\$ 1,499,578	70	

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,710,547	\$ 182,389		\$ 160,898	\$ (21,491)	\$ 1,499,578	1
2									2
3									3
4	Related Party-Forum:								4
5	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	5
6	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	6
7	Leasehold Improvement-Tenant Improvement	1987	996		13			996	7
8	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	8
9	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	9
10	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	10
11	Leasehold Improvement-Asphalting	2000	98		3			98	11
12	Leasehold Improvement-DAI	2001	172	17	10	17		54	12
13	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	13
14	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	14
15	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	15
16	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	16
17	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		\$ 5,796,243	\$ 184,778		\$ 163,287	\$ (21,491)	\$ 1,561,007	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,796,243	\$ 184,778		\$ 163,287	\$ (21,491)	\$ 1,561,007	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,796,243	\$ 184,778		\$ 163,287	\$ (21,491)	\$ 1,561,007	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 578,144	\$ 47,793	\$ 47,793	\$		\$ 161,595	71
72	Current Year Purchases	11,099	1,886	1,886			1,886	72
73	Fully Depreciated Assets	89,202	1,862	1,862			89,202	73
74								74
75	TOTALS	\$ 678,445	\$ 51,541	\$ 51,541	\$		\$ 252,683	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car engine/bus/van	:dodge/other	98-'03	\$ 8,164	\$ 130	\$ 130	\$	3	\$ 7,981	76
77										77
78										78
79										79
80	TOTALS			\$ 8,164	\$ 130	\$ 130	\$		\$ 7,981	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,832,852	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 236,449	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 214,958	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (21,491)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,821,671	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**Evanston**  
**2003 MEDICAID COST REPORT**  
**SCH XI, SECTION C, PAGE 13**  
**LINES 37-41**

	<u>COST</u>	2003 <u>CURRENT</u> <u>BOOK DEPR.</u>	2003 <u>ST LINE</u> <u>DEPR.</u>	<u>ADJUSTMENT,</u> <u>IF ANY</u>	12/31/2003 <u>ACCUM.</u> <u>DEPR.</u>
<b>F&amp;F AND EQUIP. NOT FULLY DEPREC.</b>					
<u><b>ON PRIOR PURCHASES</b></u>					
Related Party-Ams	28,323.00	5,811.00	5,811.00	0.00	14,010.00
Related Party-Forum				#VALUE!	
Computers	3,671.42	734.00	734.00	0.00	1,304.64
F & F	37,539.90	3,248.00	3,248.00	0.00	13,190.97
Equipment/Maj. Mov.	80,160.00	9,437.00	9,437.00	0.00	27,443.69
Partnership	428,450.00	28,563.33	28,563.33	0.00	105,645.21
Off book equip./F & F			0.00	0.00	
<b>SUBTOTAL LINE 37</b>	<b>578,144.32</b>	<b>47,793.33</b>	<b>47,793.33</b>	<b>#VALUE!</b>	<b>161,594.51</b>
<u><b>ON CURRENT PURCHASES</b></u>					
Related Party-Ams	2,268.00	734.00	734.00	0.00	734.00
Related Party-Forum			0.00	0.00	
Computers					
F & F					
Equipment/Maj. Mov.	8,831.00	1,152.00	1,152.00		1,152.00
Partnership			0.00	0.00	
Off book equip./F & F			0.00	0.00	
<b>SUBTOTAL LINE 38</b>	<b>11,099.00</b>	<b>1,886.00</b>	<b>1,886.00</b>	<b>0.00</b>	<b>1,886.00</b>
<b>FULLY DEPRECIATED ASSETS</b>					
Related Party-Ams	47,882.00	1,478.00	1,478.00	0.00	47,882.00
Related Party-Forum			0.00	0.00	
Computers	919.00		0.00	0.00	919.00
F & F	21,352.00	112.00	112.00	0.00	21,352.00
Equipment/Maj. Mov.	19,049.00	272.00	272.00	0.00	19,049.00
Partnership			0.00	0.00	
Off book equip./F & F			0.00	0.00	
<b>SUBTOTAL LINE 39</b>	<b>89,202.00</b>	<b>1,862.00</b>	<b>1,862.00</b>	<b>0.00</b>	<b>89,202.00</b>
<b>TOTAL LINE 41</b>	<b>678,445.32</b>	<b>51,541.33</b>	<b>51,541.33</b>	<b>#VALUE!</b>	<b>252,682.51</b>

TEST:

AMOUNTS FROM SPREADSHEETS:  
S/B ZERO

#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party - cost is backed out

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease 8534.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 3,353 Description: Copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Transport non-patient</u>		\$ <u>712.00</u>	\$ <u>2,163</u>	17
18					18
19	<u>Related Party - AMS</u>			<u>4,953</u>	19
20					20
21	TOTAL		\$ <u>712.00</u>	\$ <u>7,116</u>	21

10. Effective dates of current rental agreement:

Beginning 4/1/2000  
Ending 4/30/2020

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 12/31/2005 \$ 792,867  
13. 12/31/2006 \$ 792,867  
14. 12/31/2007 \$ 792,867

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled nurses on site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	39-3	hrs	\$	
2	Licensed Speech and Language Development Therapist	39-3	hrs			27,950			27,950	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			363,760			363,760	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16A	# of prescrpts				192,336		192,336	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify):	see pg 16A				(38,596)	240,619		202,023	13
14	TOTAL			\$		\$ 615,550	\$ 432,955	\$	1,048,505	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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## Page 16

Col 5: PT,OT, &amp; ST

Col 6: Other

Amount

## XIV. SPECIAL SERVICES (Direct Cost)

## Service

1. OT	39-3	\$262,436.00
2. ST	39-3	27,950.00
3.		
4. PT	39-3	363,760.00
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16A	247,607.00
Plus: Related Party- Forum Drugs		(34,036.00)
Plus: Related Party- Forum I.V.		(21,235.00)
Total to line 9 Pharmacy		192,336.00
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	0.00
12. Exceptional Care-Column 6	See pg 16A	0.00
13. Other: Lab, x-ray therapy, Mattress, Pyramid billings		278,628.00
Related Party- Pyramid		(38,009.00)
Related Party- CPT		(38,596.00)
Total to line 13		202,023.00
14. Total		1,048,505.00



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Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

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## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	18,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (75,000) )	544,436	544,436	3
4	Supply Inventory (priced at )	794	794	4
5	Short-Term Investments			5
6	Prepaid Insurance		17,515	6
7	Other Prepaid Expenses	1,638	1,638	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 546,868	\$ 582,557	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		980,000	13
14	Buildings, at Historical Cost		6,278,135	14
15	Leasehold Improvements, at Historical Cost	290,058	290,058	15
16	Equipment, at Historical Cost	186,028	614,478	16
17	Accumulated Depreciation (book methods)	(238,124)	(1,128,708)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		260,099	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(34,680)	20
21	Restricted Funds		145,438	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 237,962	\$ 7,404,820	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 784,830	\$ 7,987,377	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,749,194	\$ 1,808,969	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	32,433	32,433	28
29	Short-Term Notes Payable	87,955	87,955	29
30	Accrued Salaries Payable	179,774	179,774	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,573	11,573	31
32	Accrued Real Estate Taxes(Sch.IX-B)		208,700	32
33	Accrued Interest Payable		52,004	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accrued exp.ins,IDPA	80,685	80,685	36
37	Due to Affiliates	4,506,411	4,184,645	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 6,648,025	\$ 6,646,738	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	31,337	7,743,084	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 31,337	\$ 7,743,084	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 6,679,362	\$ 14,389,822	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (5,894,532)	\$ (6,402,445)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 784,830	\$ 7,987,377	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,228,460)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2003 cost report	13,118	3
4	was submitted. No effect on prior years report.		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,215,342)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(679,190)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (679,190)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (5,894,532)	24 *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

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**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,749,436	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,749,436	3
<b>B. Ancillary Revenue</b>			
4	Day Care	6,580	4
5	Other Care for Outpatients		5
6	Therapy	11,347	6
7	Oxygen	547	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 18,474	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	248	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,145	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(8,093)	19
20	Radiology and X-Ray		20
21	Other Medical Services	22,143	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,443	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	104	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 104	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 218	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,784,675	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,041,765	31
32	Health Care	1,488,647	32
33	General Administration	1,330,784	33
<b>B. Capital Expense</b>			
34	Ownership	1,399,182	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,180,429	35
36	Provider Participation Fee	23,058	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,463,865	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(679,190)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (679,190)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name &amp; ID Number Alden Estates of Evanston

# 0040733

Report Period Beginning: 1/1/2004

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## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,786	1,968	\$ 70,376	\$ 35.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,746	17,498	481,974	27.54	3
4	Licensed Practical Nurses	6,153	6,444	138,157	21.44	4
5	Nurse Aides & Orderlies	32,529	34,295	386,912	11.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,980	2,118	29,475	13.92	8
9	Activity Director	840	858	16,060	18.72	9
10	Activity Assistants	5,306	5,720	66,393	11.61	10
11	Social Service Workers	1,936	2,072	35,057	16.92	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	45,456	21.85	13
14	Head Cook	6,498	7,094	100,947	14.23	14
15	Cook Helpers/Assistants	24,010	25,312	241,447	9.54	15
16	Dishwashers					16
17	Maintenance Workers	1,224	1,258	25,812	20.52	17
18	Housekeepers	8,128	8,386	64,275	7.66	18
19	Laundry	4,459	4,971	45,952	9.24	19
20	Administrator	2,080	2,080	73,110	35.15	20
21	Assistant Administrator					21
22	Other Administrative	3,934	4,258	93,123	21.87	22
23	Office Manager					23
24	Clerical	4,600	4,776	57,218	11.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,765	2,005	62,066	30.96	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,918	133,193	\$ 2,033,810 *	\$ 15.27	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	67,950	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,376	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	59	2,632	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	59	\$ 72,958		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	Ownership %	Amount \$
Michael Gottesman	Administrator	0	73,110
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,110
B. Administrative - Other			
Description			Amount \$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount \$
AMS	Management Fees		399,537
Bdo Seidman	Accounting Fees		10,544
Ken Fisch/Greenburg	Legal Fees		17,048
Neal Gerber	Legal Fees		17,379
Medicom	Billing Consult		593
Kenneth Fisch	Legal fees-Collections		15,083
Dart Chart Systems,LLC	Medicare Consultant		76,544
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 536,728
D. Employee Benefits and Payroll Taxes			
Description			Amount \$
Workers' Compensation Insurance			38,810
Unemployment Compensation Insurance			31,799
FICA Taxes			150,993
Employee Health Insurance			40,440
Employee Meals			22,808
Illinois Municipal Retirement Fund (IMRF)*			
Dental/life insurance			889
Employee Drug Test			1,200
Employee Vaccinations			1,197
401K Match			314
Emp relations/Misc PR			5,477
Mkt manager benefits			(256)
TOTAL (agree to Schedule V, line 22, col.8)			\$ 293,671
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount \$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount \$
IDPH License Fee			
Advertising: Employee Recruitment			1,152
Health Care Worker Background Check (Indicate # of checks performed <u>47</u> )			328
Surety bond fees, dues & subscriptions			6,797
IL Health Care Assoc			322
Related party AMS			119
Less: Public Relations Expense			( )
Non-allowable advertising			( )
Yellow page advertising			( )
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 8,718
G. Schedule of Travel and Seminar**			
Description			Amount \$
Out-of-State Travel			
In-State Travel			
Travel reimbursement			(1,022)
Auto/gas expense			270
Seminar Expense			
American Express			230
Related Party AMS			2,951
Entertainment Expense			( )
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 2,429

\* Attach copy of IMRF notifications

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Plumbing repairs	11/96	1,897	15	\$ 126	126	126	126	126	126	126	126	\$
2	A/C repairs	6/97	1,720	3									
3	Painting	9/00	3,856	3	1,285	1,285	858						
4	Painting	11/02	5,491	3		305	1,830	305	1,526				
5	Painting	11/02	3,511	3		195	1,171	195	974				
6	Painting	1-12/98	7,231	3	1,218								
7	Painting>1,500 ytd 1999	7/99	6,140	3	2,047	1,023							
8	Pipe Work - Capps	9/03	865	5			96	96	173	173	173	77	
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 30,711		\$ 4,676	\$ 2,934	\$ 4,081	\$ 722	\$ 2,799	\$ 299	\$ 299	\$ 203	\$

Facility Name & ID Number Alden Estates of Evanston

STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. II Healthcare Assoc \$3861
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,888 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 23,058  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,808 Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ n/a
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: BDO Seidman,LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet issued
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Evanston  
Reporting Period Beginning  
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Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(22,808)	Employee Meal
	22	22,808	Employee Meal
22		(832)	Uniforms
	10	185	Uniforms
	6	89	Uniforms
	4	79	Uniforms
	1	284	Uniforms
	3	195	Uniforms
	11	0	Uniforms
	21	0	Uniforms
<hr/>			
0			Net should be 0



Feb-04	3/4/2004	ALDBEN Alden E	6413.22	Jan-04
Mar-04	3/29/2004	ALDBEN Alden E	4129.16	Feb-04
Mar-04	3/17/2004	ALDBEN Alden E	586.47	Dec-03
Apr-04	5/4/2004	ALDBEN Alden E	666.89	9906056
Apr-04	5/4/2004	ALDBEN Alden E	256.52	9906030
May-04	6/2/2004	ALDBEN Alden E	1426.86	9906096-apr-04
Jun-04	6/21/2004	ALDBEN Alden E	573.34	9906130-may
Jul-04	8/5/2004	ALDBEN Alden E	-74.79	april 7@15%
Jul-04	8/5/2004	ALDBEN Alden E	-30.05	may 7@15%
Jul-04	7/28/2004	ALDBEN Alden E	480.3	9906171-jun
Aug-04	9/2/2004	ALDBEN Alden E	1211.71	9906217
Oct-04	10/22/2004	ALDBEN Alden E	528.73	9906286
Oct-04	10/8/2004	ALDBEN Alden E	522.3	9906250
Nov-04	11/17/2004	ALDBEN Alden E	965.35	9906333
Dec-04	1/10/2005	ALDBEN Alden E	734.28	9906411
Dec-04	12/30/2004	ALDBEN Alden E	1204.13	ADJ/02-Prior
Dec-04	12/17/2004	ALDBEN Alden E	4645.69	9906374

24240.11